DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Delaware Confidential Morbidity Report–Sexually Transmitted Diseases

Patient Name (Last, First, MI)

SSN

Age

Sex ☐ M ☐ F

Phone

Date of Birth / /

Patient Address **City** **State** **Zip**

Pregnant
☐ Yes ☐ No
☐ Unknown
☐ Prev 12 months

Race
☐ White ☐ Asian/Pacific Islander ☐ Unknown
☐ Black ☐ American Indian/Alaskan Native

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Marital Status
☐ Married
☐ Single
☐ Other/Unknown

Laboratory Tests (1)

N. gonorrhea

☐ Confirmed Positive
by _____
☐ Presumptive Positive
Beta Lactamase Positive ☐
Negative ☐

Date_____

C. *trachomatis*

☐ Confirmed Positive
by _____

Date
_____

Syphilis

RPR ☐ Reactive _____dls
☐ Non-reactive

VDRL ☐ Reactive _____dls

TP-PA ☐ Reactive
☐ Non-reactive

FTA-ABS ☐ Reactive
☐ Non-reactive

Other ☐ _____

_____

Date _____

Reported by: (3)

_____
Laboratory Name Phone

_____
Address

_____

Date Reported _____

Diagnosis (2) Syphilis (check only one)

☐ Primary
☐ Secondary
☐ Early latent (<1 year)
☐ Late latent (>1 year)
☐ Congenital (See Cong. Section)
☐ Neurosyphilis

Chlamydia (check only one)

☐ Asymptomatic
☐ Symptomatic
☐ Pelvic Inflammatory Disease
☐ Conjunctivitis
☐ Other _____

Site
☐ Cervix
☐ Urethra
☐ Other _____

Gonorrhea (check only one)

☐ Asymptomatic
☐ Symptomatic
☐ Pelvic Inflammatory Disease
☐ Disseminated
☐ Conjunctivitis
☐ Antibiotic resistant
☐ Other _____

Site

☐ Cervix
☐ Urethra
☐ Rectum
☐ Pharynx
☐ Other _____

Other STDS (check all that apply)

☐ NGU
☐ Herpes
☐ Chancroid
☐ Mucopurulent Cervicitis
☐ HIV
☐ Granuloma inguinale
☐ Human Papilloma Virus
☐ Lymphogranuloma Venereum
☐ Other (specify) _____

Congenital Syphilis (4)

Infant Information

☐ Live Birth ☐ Weight in grams _____

☐ Still birth ☐ Born alive, then died Date_____

Estimated gestation age (weeks) _____

☐ Darkfield Positive

Long Bones X-rays ☐ Positive ☐ Negative

CFS VDRL ☐ Reactive ☐ Non-reactive

WBC >5/mm3 ☐ Yes ☐ No

Protein >50 mg/dl ☐ Yes ☐ No

☐ Hepatosplenomegaly
☐ Cutaneous lesions
☐ Snuffles
☐ Asymptomatic
☐ Other _____

Maternal Information

Mother's Name _____

Medical Record Number _____

Mother's Birth Date _____

Mother's Race ☐ White ☐ Black
☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander

Ethnicity ☐ Hispanic ☐ Non-Hispanic

Mother's Diagnosis _____
(Stage)

by _____
(Physician)

Prenatal Care _____/_____/_____
(Date First Visit)

Total visits _____

☐ **No Prenatal Care**

Mother's Serology History

	Date	Titer		Date	Result
RPR			**FTA**		
RPR			**TP-PA**		
RPR					

Treatment (5) Based upon Diagnosis section 2

Date_____/_____/_____

☐ 2.4 mu Benzathine Pen G

☐ 7.2 mu Benzathine Pen G

☐ Ceftriaxone Sodium

☐ 125 mg ☐ 250 mg

☐ Ciprofloxacin 500 mg

☐ Azithromycin 1 gm

☐ Doxycycline 100 mg BID X

☐ 7 days ☐ 14 days ☐ (Other) _____days

Other Treatment and Dosage

_____

Reported by (6)

Date ____/____/_____

Name _____

Facility _____

Address _____

City _____

State _____ **Zip** _____

Phone _____

Please mail completed pages of this form to: The Division of Public Health STD Program Office at 417 Federal Street, Dover, DE 19901. If you need to contact us with questions or request a copy of the DPH reporting regulations please call at (302) 744-1025 or visit our web site at http://www.dhss.delaware.gov/dhss/dph/dpc/stds.html

Revised August 2007
Doc. #35-05-20/07/08/08